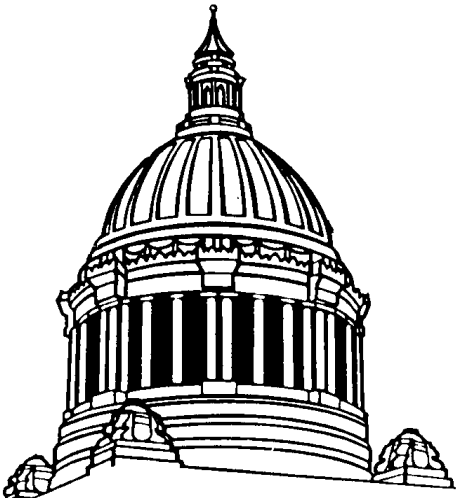

State of Washington
Joint Legislative Audit and
Review Committee

Quality Assurance of In-Home Care Services

Report 99-2

February 16, 1999

Upon request, this document is available in alternative formats for persons with disabilities.

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Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other types of policy and fiscal studies. Study reports typically focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included. The Legislative Auditor also has responsibility for facilitating implementation of effective performance measurement throughout state government.

The JLARC generally meets on a monthly basis during the interim between legislative sessions. It adopts study reports, recommends action to the legislature and the executive branch, sponsors legislation, and reviews the status of implementing recommendations.

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TABLE OF CONTENTS

Chapter		Page
	SUMMARY	**i**
	SUMMARY OF RECOMMENDATIONS	**vii**
1	**BACKGROUND AND STUDY APPROACH**	**1**
	Study Overview	1
	History of In-Home Care	2
	Background on Current Program	3
	Study Focus and Approach	5
2	**IN-HOME CARE: DYNAMICS AND QUALITY ASSURANCE**	**7**
	Summary	7
	The Meaning of "Quality Assurance"	8
	Quality Assurance Practices	8
	In-Home Care: Design and Implementation Issues	14
	Conclusion	23
	Recommendations	24
3	**IN-HOME CARE: DIFFERENCES BETWEEN INDIVIDUAL PROVIDER- AND AGENCY-SERVED CLIENTS**	**25**
	Summary	25
	Comparison of IP-Served and Agency-Served Clients	25
	Growth in Use of Individual Providers	28
	Implications of the 112-Hour Rule	30
	Options For Providing Quality Assurance For Individual Providers	32

Chapter		Page
	Conclusion	32
	Recommendation	33

Appendices

1	Scope and Objectives	35
2	Agency Responses	37
3	Illustrative Indicators Of Home Care Quality	43
4	Comparison Of Agency and IP Clients By "Vulnerability" Factors	45

QUALITY ASSURANCE OF IN-HOME CARE SERVICES

Summary

BACKGROUND ON IN-HOME CARE

Overview

In-home care services are available through Medicaid to seniors and individuals with disabilities. These individuals are nursing home eligible, but able to remain at home if they receive personal care assistance with tasks such as bathing, ambulating, and meal preparation. Approximately 20,000 clients in Washington State receive Medicaid-funded in-home care services at an average monthly cost of $700 per client. The number of clients in the in-home care program has increased over 60 percent in the last eight years.

The program is administered by the Department of Social and Health Services' (DSHS) Aging and Adult Services Administration (AASA), and most services are coordinated by 13 Area Agencies on Aging (AAA). Many parties are involved in providing oversight and quality assurance including AASA, the AAAs, home care agencies, and the Department of Health (DOH).

Two service delivery options

There are two types of in-home care delivery options. A client can choose to receive services from a home care agency, which recruits and hires caregivers and is responsible for ensuring a worker is available for the client's scheduled hours. The other option is to use an Individual Provider (IP), a caregiver whose services are funded by the state but who is actually a direct employee of the client. With assistance from the AAA case manager, the client is responsible for hiring, supervising, and finding replacements for the caregiver. IP clients therefore have more supervisory responsibilities than agency clients do and, as a result, agency

services are more costly. Because of the direct employment relationship, IP caregivers can often provide more flexible and extended-service hours. In recent years, the number of IP clients has been increasing while the number of agency clients has leveled off.

STUDY PURPOSE

Evaluate QA practices of in-home care system

The Joint Legislative Audit and Review Committee (JLARC) initiated this study in response to requests from several legislators concerned that clients may be at high risk of harm or neglect by caregivers when receiving services in their home. Concern was also expressed that there is less accountability for clients served by IPs than those served by home care agencies.

The purpose of this study was to:

1. Determine how well the system is designed to provide for quality assurance (QA).
2. Evaluate how well the system is implemented.
3. Compare the vulnerability of clients served by home care agencies and IPs.

FINDINGS

Design and Implementation

We found that the in-home care delivery system has many quality assurance practices in place. Among these are:

Many QA practices evident

- Required, standardized training for all caregivers
- Basic employment requirements for all caregivers
- Mandatory yearly case manager visits
- DOH licensure for home care agencies
- AAA contract requirements and annual monitoring of home care agencies
- Monitoring of AAAs by the state

Many of these quality assurance practices used by AASA and the AAAs to monitor agency subcontractors emphasize administrative requirements. While these are important elements in a quality control system, our review of current research on home care quality suggests that current quality assurance practices could be strengthened if they also included performance and program results monitoring. In addition, we found that many of the system's quality assurance practices apply to clients served by home care agencies, but not to clients within the IP program.

Practices should be more performance-based

The case management responsibilities of AAAs for Medicaid-funded in-home care programs increased significantly with long-term care reform in 1995. However, we found that AASA has not integrated these changes into its AAA oversight practices.

Finally, our review shows that AASA Adult Protective Services does not track whether the victims of abuse or neglect are receiving Medicaid services, have an IP or agency caregiver, or whether the alleged perpetrator is a state-funded caregiver.

IP Payment System

Our study found that IPs report working a significantly higher percentage of their authorized hours than do agency workers. While there may be some legitimate reasons for the difference, the limited accountability and controls within the IP payment system are a concern, and our report makes recommendations to address this issue.

Client Vulnerability

The IP caseload is growing at a faster rate than the agency caseload, which means an increasing percentage of clients are entering the part of the in-home care system that has fewer quality assurance oversight elements in place. To see if this should be a concern, we analyzed and compared the assessment profiles of agency- and IP-served clients.

IP cases growing more rapidly

The results show that IP-served clients score higher on vulnerability indicators than agency-served clients. Why these

IP clients more "vulnerable"

more “vulnerable” clients are more likely to use IPs is not fully apparent. Both personal factors, such as living situations and language skills, and some state policies appear to influence a client's “choice” of provider.

One key AASA policy requires that elderly and disabled clients use an IP when they need more than 112 hours of monthly care. The objective of this policy is to provide the most amount of care and service flexibility at the least cost. Depending on their needs and level of independence, many clients in this category may be able to adequately supervise their caregiver and self-direct their care. However, this policy may also place other, potentially more vulnerable, clients into a care environment with fewer quality controls.

Growing IP cases require QA attention

The ultimate outcomes of these policies, in terms of long-term impacts on client health and ability to defer nursing home placement, are unknown to AASA and could not be determined within the scope of this study. However, given the important role this state policy has in determining a client’s choice of provider and the growing number of IP cases, the difference in quality assurance oversight between the IP and home care agency programs is a cause for concern.

AGENCY RESPONSE

We have shared the report with the Department of Social and Health Services and the Office of Financial Management. They have submitted responses, which concur with the report's recommendations. Their comments are attached as Appendix 2.

ACKNOWLEDGEMENTS

We sincerely appreciate the cooperation extended to us by the staff of the Aging and Adult Services Administration, Division of Home and Community Services, as well as by the staff of the Area Agencies on Aging whom we interviewed and visited.

This study was conducted by JLARC staff members Beth Keating and Elizabeth DuBois, with assistance from Duke Kuehn, Pacific

Northwest Consulting. Beth Keating was the project leader and Tom Sykes was the project supervisor.

Thomas M. Sykes
Legislative Auditor

On February 16, 1999, this report was approved by the Joint Legislative Audit and Review Committee and its distribution authorized.

Representative Cathy McMorris
Chair

RECOMMENDATIONS

Summary

Recommendation 1

The Aging and Adult Services Administration should incorporate performance monitoring elements of case management services into its monitoring of the Area Agencies on Aging.

Legislation Required:	None
Fiscal Impact:	None
Implementation Date:	January 2000

Recommendation 2

The Aging and Adult Services Administration should strengthen the accountability controls over the Individual Provider payment system.

Legislation Required:	None
Fiscal Impact:	Unknown. This recommendation requires additional external oversight of IP payment invoices. At a minimum, it will require additional personnel time to review IP payment claims. AASA has included a request for an IP "brokerage" system in the Governor's 1999-2001 budget, which would include a fiscal intermediary function to improve IP payroll controls, however no detailed cost estimates of this function are yet available. If this project is not funded, there are other options, such as requiring the client to sign off on payment invoices, which would add *some* additional accountability at a lower cost.
Implementation Date:	January 2000

Recommendation 3

The Aging and Adult Services Administration should resolve the data tracking and communication problems with Adult Protective Services.

Legislation Required:	None
Fiscal Impact:	None
Implementation Date:	Implementation of this recommendation is currently in progress.

Recommendation 4

The Aging and Adult Services Administration should improve its quality assurance controls for the more vulnerable clients within the Individual Provider program.

Legislation Required:	None
Fiscal Impact:	Unknown. Additional staff resources may be required to target resources to more vulnerable clients without reducing existing QA oversight for less vulnerable clients. AASA has requested additional case management funding in the Governor's 1999-2001 budget, part of which would be used to accomplish this goal. In addition, a portion of the costs of the proposed IP "brokerage" will cover additional services to assist clients (and case managers) with IP employment and supervision.
Implementation Date:	January 2000

BACKGROUND AND STUDY APPROACH

Chapter One

STUDY OVERVIEW

At the request of legislators, the Joint Legislative Audit and Review Committee (JLARC) conducted a review of the Department of Social and Health Services' (DSHS) Aging and Adult Services Administration (AASA) quality assurance practices for in-home care services for the elderly and persons with disabilities. The two principal, publicly-funded means of delivering in-home care are through home care agencies and through Individual Providers (caregivers who are independently employed by a client).

Our review shows that many quality assurance practices and requirements are currently in place. However, while these practices are an important part of a quality assurance system, we found that they tend to include mostly administrative requirements, rather than focussing on program or performance results monitoring. This report recommends that AASA improve its current quality assurance practices by further emphasizing performance and by integrating oversight of Medicaid home care case management with existing reviews of the AAAs.

Practices should be more performance-based

Our study also shows that many of the quality assurance and oversight practices currently in place apply to agency-delivered services and not to the Individual Provider (IP) program. Like agency caregivers, IPs must meet state-established employment requirements. However, on-going IP supervision is the client's responsibility and little additional external accountability exists. According to available data, IPs also appear to serve a more vulnerable population than agencies do. Our analysis shows that

20 percent of IP clients live alone and are judged by caseworkers to lack the ability to effectively supervise their IPs. As a result, this report recommends that AASA improve its quality assurance controls for the more vulnerable clients within the IP program.

HISTORY OF IN-HOME CARE

Increase in nursing-home alternatives

Significant changes in Washington State's long-term care system have taken place in recent years. In accordance with state policy, community-based alternatives to nursing facilities have been increasing in number and popularity, and among these is the delivery of in-home care for frail elderly and disabled persons. Beginning in the 1970s, AASA began authorizing CHORE services to elderly clients, which provided assistance with daily household tasks such as cooking and cleaning. AASA first used the IP program to deliver these services, through which independent caregivers contract with the state to provide in-home services to clients. In the late 1970s, AASA also began contracting with home care agencies to deliver CHORE services.

In the early 1980s, the federal Medicaid waiver program COPES (Community Options Program Entry System) was launched to provide low-income, nursing home-eligible, clients with assistance with personal care tasks, thereby enabling them to remain at home rather than be admitted to a nursing facility. In 1990, the state also began participating in the federal Medicaid Personal Care (MPC) program, which provides personal care assistance to elderly, low-income, clients in their homes. AASA contracted with the AAAs to provide case management and to coordinate the delivery of these services to elderly clients. In 1995, their case management responsibilities were expanded to include the younger (under 60) disabled population.[1]

Change in nature of care provided

These changes in federal and state policy meant that some clients who would previously have been admitted to, or at risk of being placed in, a nursing facility could now receive care at home. This necessitated a change in the type of in-home care required, shifting from more routine household task assistance, to personal care tasks such as physical assistance with ambulating, bathing,

[1] RCW 74.39A.

and toileting. The amount of daily or weekly assistance needed for in-home care clients also increased.

It is important to note that these in-home care services are not medical in nature. While in-home care clients may have multiple medical problems, personal care services are intended to assist clients with compensating for physical and cognitive *functional* disabilities. There are other programs, such as Home Health, whose purpose is to provide health care and medical treatments to clients in their homes. Exhibit 2 at the end of the chapter provides some sample profiles of in-home care clients drawn from our case file reviews.

Services are functional, not medical

BACKGROUND ON CURRENT PROGRAM

There are approximately 20,000 clients in Washington receiving in-home personal care services. Services are either provided by state-funded IPs who work directly for the client, or by caregivers employed by home care agencies. IPs were originally few in number and mostly provided care to clients needing either a large amount of service hours (over 85 per month) or a live-in provider, however their numbers have been increasing.[2] In 1995, AASA expanded the program to allow clients to use IPs even if they need fewer than 85 hours of monthly care.[3] The overall number of in-home care clients is also increasing. Since 1990, caseloads have increased by 160 percent, with IP clients growing at a faster rate than agency clients.

Care is provided by IPs or agencies

According to AASA, expenditures for personal care services in FY 1998 were $171.5 million with 50 percent coming from the state general fund. In FY 1998, the average monthly cost per client for in-home services was approximately $700. IPs are currently reimbursed at a rate of $6.18 per hour, and agencies are reimbursed $11.33 per hour. Exhibit 1 demonstrates some of the differences between the agency and IP programs.

[2] AASA Management Bulletins.

[3] This expansion was in response to disability advocates for the younger disabled population, who requested more consumer-directed care options.

Exhibit 1

What Are Some Differences between A Home Care Agency And Individual Provider?

Responsibility	Agency	IP
Who employs the caregiver?	Agency	Client
Who screens and hires the caregiver?	Agency	Client (with case manager assistance)
Who supervises the caregiver?	Agency Supervisors & Client	Client
Is the provider licensed?	Yes, by Department of Health	No
Who plans the work schedule?	Agency and Client	Client
Who arranges for substitute care?	Agency	Client

Source: AASA new client orientation material.

Recent changes to in-home care delivery

In 1995, the Washington State Legislature passed House Bill 1908, making many changes in Washington's long-term care programs. Some of those changes included encouraging community-based care over nursing home care, moving case management responsibility for the under-60 disabled population to the AAAs (who were already responsible for clients over 60), and reorganizing authorization and assessment responsibilities between AASA and the AAAs.[4] All clients are now initially assessed and authorized by AASA and receive on-going case management services and reauthorization from the AAAs. Based on assumptions that the under-60 cases would be less complex, and a staffing model that assumed a minimal amount of time would be required to manage them, AAA caseloads were increased from 50 to 100 clients per full-time case manager. Previously existing standards for quality control monitoring, such

[4] There are 13 AAAs created under federal authority that advocate and provide services to seniors and people with disabilities. AAAs are further discussed in Chapter Two.

as monthly client contact and more frequent nurse oversight visits, were thus significantly reduced.

STUDY FOCUS AND APPROACH

JLARC initiated this study in response to requests from several legislators concerned that clients may be at high risk of harm or neglect when receiving services in their home. Concern was also expressed that less accountability exists for IPs, who are supervised by the client and not another external party, than exists for agency caregivers.

JLARC initiated this study

Methodology

Our study's purpose was to determine how well the system is designed to provide for quality assurance and how well the system is implemented as designed. To address the issue of quality assurance, we reviewed the system's design and operations against state statutes, Washington Administrative Codes (WAC), and AASA policy and procedure requirements. Our review included interviews with AASA staff/program managers, site visits to six AAAs, and client case file reviews. To compare IP and agency client vulnerability, we accessed AASA data systems and used client assessment and payment data for July 1998. Our data included almost 16,000 clients, representing approximately 80 percent of all in-home care clients in the state.

We focused on the following types of questions, reviewing the in-home care delivery system to determine whether anyone has the responsibility to look for these problems, and whether the system is designed to prevent them:

Research questions asked

- Where is the oversight in the system that provides in-home care? Does it work? Are there any gaps?
- If a client is being abused, neglected, or financially exploited, how would those involved in administering the program know?
- What do we know about the clients who are served by IPs - are they more vulnerable than agency clients?

Information was not readily available to answer specific outcome-oriented questions such as whether caregivers are reliable, are providing quality care, and are not financially exploiting or harming their clients. In addition, it is unknown whether clients served by IPs and agency caregivers are equally successful at remaining stable in their homes.

Chapter Two discusses how well the system is designed and implemented to provide for quality assurance. Chapter Three discusses recent trends within in-home care caseloads, and whether clients served by IPs are more vulnerable than those receiving care from agency providers.

Exhibit 2

Who is a "typical" in-home care client?

Examples of home care clients

Margaret is 62. She has been diagnosed with emphysema and deteriorating vertebrae. While her health problems are serious, they are chronic, not acute. However, she needs about 20 hours of assistance per week with personal hygiene and house cleaning. She has an agency caregiver.

Stanley is a 30-year-old male who was disabled by a gunshot wound to the head. He uses a wheelchair and has a part-time job, but for about ten hours per week needs help bathing and dressing. He uses a caregiver from an agency.

Yankel is diabetic, 67 years old, and has recently had an angioplasty. Since his wife is not able to care for him, his daughter works as his IP and comes in a few hours a day to assist with dressing, cooking, and cleaning.

Gwendolyn is 81, blind from diabetes, has cardiovascular problems, arthritis, and dementia. She has a live-in caregiver receiving the monthly maximum IP rate, which reflects about 184 hours of paid care. However, in reality her IP is providing much more care since she is there 24-hours-a-day, seven-days-a-week.

Source: JLARC case file reviews.

IN-HOME CARE: DYNAMICS AND QUALITY ASSURANCE

Chapter Two

SUMMARY

Many entities are involved with the delivery of personal care provided in the home. We found that this system has much strength in its oversight of in-home care services, particularly of those provided by contracted agencies. However, the current oversight and monitoring elements tend to emphasize administrative and fiscal requirements. While these are important elements in a quality control system, our review of current research on home care quality suggests that current quality assurance practices could be strengthened if they also included monitoring of program performance.

In addition, we found that many of the existing quality assurance practices apply to clients served by home care agencies, but not for clients within the IP program. While it is not known if these additional practices actually produce a higher quality of care, we are concerned about the limited amount of oversight and accountability within the IP program.

The following section discusses the term "quality assurance," outlines the responsibilities of various parties in the system, and discusses current quality assurance practices. We also review and discuss issues related to the development and implementation of in-home care services that emerged from our audit.

Chapter overview

THE MEANING OF "QUALITY ASSURANCE"

Definition of QA depends on program goals

"Quality assurance" for in-home care can be defined in multiple ways. There is no correct definition, just a preference that depends on a program's purpose and focus.[1] The system for in-home care services in Washington does not recognize one definition for quality assurance. Increasing public financing of community-based long-term care reflects a public policy to provide clients with an opportunity to remain in the most independent setting possible for them, as well as to avoid the higher costs of nursing home placement. Therefore, some constituencies may view quality assurance as insuring the system meets client's personal health needs. Others may view quality assurance as a way of ensuring that the program is meeting the policy goal of reducing demand for nursing home beds. And still others are more interested in client satisfaction with the services and options offered and would expect quality assurance efforts to be directed toward those aspects of service. Like other states, Washington has constituencies interested in all of these aspects of quality assurance and its in-home care system reflects many of them.

Quality assurance may be formalized as a specific program, or practices may exist without being particularly identified as quality assurance. The latter is the case for Washington's in-home care system. There are components of quality assurance in the system, but they are generally not packaged as a specific program.

QUALITY ASSURANCE PRACTICES

In the following section, we discuss the key parties with quality assurance responsibilities for the delivery of in-home care services, and the oversight and monitoring practices we identified

[1] Researchers at the School of Public Health at the University of Minnesota have categorized various indicators of home care quality into four groups. This framework can assist one in understanding the range of what may be meant by the term "quality assurance." Appendix 3 provides a table of the researchers' indicators of in-home care quality.

during our review. Exhibit 3 on the following page demonstrates the complexity of the system and the entities involved.

Aging and Adult Services Administration (AASA)

AASA is responsible for administering in-home care programs, and setting the program requirements and standards consistent with federal and state law. Below are examples of important quality assurance elements in which AASA is involved.

AASA administers in-home care programs

Examples of Quality Assurance Practices Evident:

- Annual monitoring of AAAs for administrative and fiscal requirements
- Standardization of client assessment tools
- Initial client assessment and service authorization
- Mandatory, standardized training for all caregivers[2]
- Criminal background check requirement for caregivers
- Minimum client home visit standards for case managers
- Some program standards in place for AAAs and their subcontractors
- Existence of a system for complaints and investigations (Adult Protective Services)

[2] In many AAAs case managers are also ultimately responsible for seeing that workers comply with state training requirements. As part of this review, we looked at how many workers were complying with the training requirements within the specified time period, and also how AAAs track worker compliance. Most of the AAAs we spoke to maintain an electronic tracking system of caregiver training and were able to provide us with information quickly that suggests that workers are fulfilling their requirements. The King County Division on Aging AAA was an exception, as it lacked a tracking system. To determine approximately what percentage of its IPs had been trained, we matched the AAA training records with our data set of DSHS payment records from July 1998. We found that 5 percent of its IPs had not been trained. However, AAA management did not have this information.

To link to this exhibit, click here.

Area Agencies on Aging (AAAs)

Out of concern for the growing population of seniors, Congress enacted the Older Americans Act (OAA) in 1964 to address the complexity of health and social issues facing the elderly. In 1974, Congress also created Area Agencies on Aging (AAAs) to advocate and develop a network of services for seniors. The AAAs currently provide on-going case management services for all Medicaid in-home care clients, which constitute the majority of AAA activities and funding.

AAAs provide case management services

Examples of Quality Assurance Practices Evident:

- Client case file management standards and supervisor reviews of case files[3]
- Nurse oversight/consultation services
- Case managers perform annual home visits, verify caregiver training, are available to assist clients when care needs change, assist with caregiver problems, and do some client monitoring[4]
- Annual monitoring of home care agency contracts
- Home visit standards for agency caregiver supervisors
- Timesheets required for all agency caregivers
- Performance evaluation requirements for agency caregivers
- Regular communication and meetings with home care agencies
- Review of case file management, including documentation and matching between the client service plan and services

[3] Department policies also require regular supervisor reviews of case files that emphasize the appropriateness and accuracy of documentation. Our file reviews found evidence that supervisor reviews did occur in some AAAs, but that they were not always regularly, or formally, conducted.

[4] Our review of client case files showed that, over a 14-month period, some clients received phone calls and on-going monitoring from case managers to monitor their care needs. However, others received no phone calls or other contact, aside from the one required annual home visit.

Department of Health (DOH)

DOH licenses home care agencies

Washington's Department of Health (DOH) licenses home care agencies to deliver in-home care services. DOH staff conduct the initial licensure review, with renewal surveys conducted by the AAAs.[5] This provides a formal structure for quality assurance.

Examples of Quality Assurance Practices Evident:

- Standards and penalties for licensure
- Initial site visits for licensure
- Renewal surveys
- Current efforts to update agreements between agencies

Home Care Agencies

Agencies subject to contractual QA requirements

Home care agencies are licensed by DOH and have contracts through the AAAs to provide in-home care services.[6] Agencies are monitored annually by AAAs for contract compliance. AAA requirements for agencies include: requirements for how client case file information is maintained, how billing is handled, minimum standards for how frequently a supervisor visits the client, timesheet requirements for caregivers, and annual performance evaluations of caregivers.

Examples of Quality Assurance Practices Evident:

- Administrative requirements for standard case file management, caregiver timesheets, and billing.

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[5] Through an interagency agreement, AAAs conduct visits to home care agencies for their licensure renewal as part of their annual contract monitoring visits. This coordination between DOH and the AAAs was the result of a JLARC (formerly LBC) study in 1992 (Report #92-9) that recommended the agencies coordinate to prevent a duplication of efforts. At the time of this review, we found that DOH and AASA have agreed to revisit their interagency agreement to provide for better communication and hopefully learn from each other about how to focus more on performance issues during their surveys of agencies for licensure renewal.

[6] Catholic Community Services operates the largest home care agency in the state.

- Program requirements for supervisor home visits and performance evaluations of caregivers.

Agency and IP Caregivers

Caregivers provide services to clients outlined in the service plan developed by AASA or by the AAA case manager. There are minimum employment standards caregivers must meet.

Caregiver employment standards exist

Examples of Quality Assurance Practices Evident:

- Meet basic employment requirements (e.g., able to understand care plans)
- Pass criminal background check
- Attend caregiver training and test (initial course is 22 hours, 10 hours required annually for continuing education)
- Demonstrate adequate performance during supervisor home visits and in performance evaluations

Clients

Clients have a central role in providing quality assurance since they can choose the type of provider they want (agency worker or IP) and oversee their caregiver on a daily basis.

Clients have central role in QA

With an IP, the client is the employer and the primary supervisor and has the authority to hire and "fire" their IP. Agency clients also have the ability to select their caregivers. The case files we reviewed had many instances where dissatisfied clients requested a change in agency caregivers, or even agencies.

Examples of Quality Assurance Practices Evident:

- The client has the authority to pick the type of provider system they want to use
- Both IP and agency clients have the authority to actively oversee their caregiver, report problems to their case manager (and agency supervisor, if applicable), and to request a new caregiver

IN-HOME CARE: DESIGN AND IMPLEMENTATION ISSUES

QA requirements differ for IPs and agencies

When considering the quality assurance components described above and the complex in-home care system design pictured in Exhibit 3, one has to consider agency and IP systems separately. Our review shows that the part of the system that delivers services through home care agencies has several layers of contractual relationships, ongoing monitoring, and multiple parties involved in quality assurance and oversight. In comparison, we found that the IP program is designed with more limited oversight and external accountability controls, most of which exists when an IP is initially hired. AASA's policy is that oversight is the responsibility of the employer, i.e., the client, and there are few other points in the system where an IP is subject to further oversight.

Agency Delivered Services: Administrative versus Performance-Based Oversight

Limited focus on program performance

For agency-delivered services, the quality assurance problem is not in the “design” of the program. On the contrary, many important elements of oversight and accountability are built in. However, our review of monitoring and quality assurance activities shows that the focus of existing requirements and monitoring is not particularly performance-based. The major policy changes of 1995 in long-term care reform (HB 1908), and the increased involvement of the AAAs in the case management of in-home care and Medicaid programs, require that greater attention be paid to performance issues.

AASA Oversight of AAAs

The entity in AASA responsible for overseeing the AAAs is the State Unit on Aging (SUA). The SUA approves AAA plans and monitors AAA administrative and fiscal operations for compliance with federal and state regulations. However, the expanded case management roles undertaken by the AAAs since 1995 have not been integrated in the oversight and monitoring practices of the SUA. For example, when monitoring the AAAs, the following types of questions are generally not considered:

- Do client case notes and files show effective case management?
- Do client service plans match the client's assessed needs?
- Did case managers meet the annual reassessment requirements?
- Are client assessments and use of special authorizations consistent with state and federal guidelines?
- Are case notes and files being reviewed by case management supervisors, per policy?
- Do case managers follow up on nurse reports and document their actions taken in response to nurse recommendations?

Given the large amount of both state and federal funding dedicated to Medicaid-funded in-home care services, we are concerned that more program or performance monitoring of their case management has generally not been incorporated into AASA oversight review.[7] Staff within AASA has acknowledged this problem and considers it an issue that needs to be addressed.

AAA Oversight of Agencies

Consistent with state law, AAAs contract with and oversee agency providers. State rules and AAA contracts include some important quality assurance elements, such as verification of worker timesheets and training completion, twice-yearly agency supervisor home visits, caregiver performance evaluations, and criminal background checks. However, this monitoring focus is, like the state-level monitoring of the AAAs, largely focused on management elements, such as keeping correct documentation and ensuring accurate billing. There are limited programmatic, or "performance-based" requirements and review elements. For example, agency clients are not routinely surveyed or interviewed for their feedback, nor are important performance questions usually asked, such as how quickly agencies provide services to new clients.

Focus on documentation, not performance

[7] The program monitoring that occurred in 1996 focused on administrative requirements and providing technical assistance to assist the AAAs with their new in-home care case-management role.

Good example of outcome monitoring

The Pierce County Aging and Long Term Care AAA, however, may illustrate a preferred future direction for this oversight and monitoring role. This AAA has recently started to require performance information from agency contractors, such as how quickly clients are matched with caregivers and how satisfied clients and AAA case managers are with agency services. While this effort is not yet integrated with its regular monitoring of agencies, the AAA requires contractors to submit performance data annually and began collecting data in 1998.

Individually Provided Services: Limited Accountability

IPs provide flexible and extended service

In the IP program, the caregiver is paid by the state to provide either CHORE or Medicaid personal care services, but is actually a direct employee of the client. With assistance from the AAA case manager, the client is responsible for hiring, supervising, and finding replacements for the caregiver. IP clients thus have more supervisory responsibilities than agency clients. Because of the direct employment relationship, and because IPs are frequently friends or family members, IP caregivers can often provide very flexible and extended service hours. For example, a significant number of IPs (approximately 16.3 percent) are on a monthly payment plan, which means they have agreed to provide an undefined amount of service (minimum of 184 hours per month) for a fixed sum of money. In many cases, these IPs live with clients who need 24-hour care and are actually providing more care than they are paid for. This program was designed, in part, to meet the needs of such clients who require extended care and flexible service hours (e.g., evenings and weekends) at a more affordable cost than agency services.

However, our review of the quality assurance controls within the IP program found some cause for concern. As with agency caregivers, IPs are required by AASA to pass a criminal background check, to complete the standard caregiver training class when initially hired, and to attend continuing education classes each year. The AAA case manager is responsible for ensuring that these basic quality assurance requirements are met, for serving as an on-going resource for IP clients should they need any assistance with their caregivers (either IP or agency),

and for completing their clients' annual reassessment and home visit.

We found that, beyond these basic elements, little external oversight authority exists to monitor IP performance, either within AASA or the AAAs. Unlike agency caregivers, the client is the only one who directly supervises the performance of the IP and his/her on-going ability to deliver quality care. According to the contract arrangement between DSHS, the IP, and the client, it is the client's responsibility to ensure that their services are delivered according to the agreed upon care plan and to notify the case manager should this not occur.

Little external oversight exists for IPs...

In contrast, agency supervisors are required to accompany their caregivers on home visits at least twice a year in order to evaluate the caregiver's performance and check the client's situation. This is in addition to the annual AAA case manager visit, which means agency clients receive a minimum of three home visits per year, compared to one per year for IP clients. In addition, agency supervisors are required by AAAs to complete regular performance evaluations of their caregivers and to ensure that time sheets are accurately maintained. Furthermore, additional layers of accountability are built into the delivery system of agency services. As discussed earlier in this chapter, AAAs monitor home care agencies to ensure that their contract requirements, such as minimum supervisor home visits, employee performance evaluations, and contract management standards, are being met.[8] AASA in turn monitors the AAAs to insure they are appropriately managing agency subcontractors.

Overall, the agency delivery system has more layers of accountability and quality assurance mechanisms in place than does the IP program. However, it is important to note that additional oversight may not be needed for all IP clients. For example, a significant number of younger disabled clients are very capable of supervising and directing their own care; they simply need *physical* assistance in accomplishing daily tasks. Additional monitoring visits for such clients would clearly not be

...but additional oversight not always needed

[8] The requirements for supervisor home visits, employee performance evaluations, and employee timesheets are part of the licensure requirements of the Department of Health, which are the AAA's monitoring responsibility.

as necessary as they would for clients with dementia or other cognitive impairments.

Effects of additional QA practices unknown...

It is also important to note that the effects of the additional quality assurance measures for agency services are not known. For example, information is not being tracked to determine if agency clients are more or less likely to avoid hospitalization or nursing home placement than are IP clients. Despite the more limited oversight in the IP program, IP clients may be receiving a higher quality of care. Such outcome information is simply not available.

...but they do provide a "safety net"

However, the additional measures do, at a minimum, provide additional opportunities for both the AAAs and AASA to identify potential client problems before they become critical, thus serving as a "safety net." Our concern is that, other than the discretion and limited resources of case managers, the IP program has virtually no *external* controls in place to monitor the more vulnerable clients and notify either the AAAs or AASA of a problem.

Role of the Case Manager in Quality Assurance

Case manager is central to QA

Every AAA has staff dedicated to following the client's progress and who are required to make on-site visits. According to the AASA policy manual, the case manager is considered the cornerstone of quality assurance. However, few standards are in place for case management. Existing requirements include one visit per year to conduct the annual client reassessment and reauthorization, and the maintenance of regular (but undefined) contact with the client. Case managers make additional visits depending on changes in client conditions and needs.

Our case file reviews found that it is possible to have anywhere from one visit per year for stable clients, to up to ten or more for those highly unstable or in crisis. Some of the more stable cases show that there can be no contact with a client during the year between their annual assessments. From case file reviews and interviews with key staff, we found that the time a case manager spends with a client appears to be largely a function of whether

the client is problematic or unstable.[9] Aside from the annually-scheduled reassessments, case managers' jobs tend to be largely reactive. Clients, workers, and family members frequently contact case managers when they need to have problems resolved. And as shown in Exhibit 4 on the following page, case managers are required to handle a broad range of problems and situations.

Case managers are responsible for annual assessments of client needs and for ensuring that the service plans are fulfilled. However, provided the service plan is being met, they are not responsible for evaluating IP caregivers' performance or ability to deliver quality care. IP caregivers are required to sign a contract with the state that they will provide a specific plan of care. Therefore, if case managers discover a problem, either through a call from the client (or a friend or relative) or during a home visit, they can take some action. Case managers can either help the client change IPs or cut off payment when it appears the plan is not being fulfilled. However, our interviews show that, in the absence of ongoing monitoring or oversight, it can be difficult for a case manager to ascertain and prove that a problem exists or a caregiver is not adequately delivering the care plan.

Case managers do not evaluate IP performance...

Role of Nurse Oversight in Quality Assurance

The Nurse Oversight Program previously provided a medical oversight visit to each client once a year, with additional visits conducted as necessary. Nurse visits were not intended to provide direct health care services, but to review the adequacy of the client's service plan and assess the caregiver's ability to provide the needed services. Outside of the initial caregiver training test that all care providers must pass, the nurse's responsibility to assess an IP's skills is the most direct review of an IP's abilities that we could identify in the system. In most of the case files we reviewed, nurse summary reports were the only written reference to a worker's ability to care for the client.

...but nurses do

[9] The amount of time spent with a client does not appear to be related to how many hours of assistance a client needs or whether they use an IP or agency worker. An exception to this was found in those AAAs that do not use assistants or program specialists to manage the business aspects (e.g., reimbursement, training compliance) of using IP workers. In those AAAs, case managers have to handle all these administrative concerns; and therefore, IP clients may require more case manager time than agency clients.

Case managers handle a range of problems

Exhibit 4

Example of Clients and Case Manager Interventions Based on Client Case Files

Wilma *is 62 and has been on services for three years. She uses agencies for 84 hours per month to help with a degenerative brain disease. In October 1998, she became erratic–yelling, burning clothes, refusing to use the toilet, and calling providers and friends with threats. The case manager has to handle multiple calls from the agency worker and supervisor because the worker is ready to quit. The case manager persuades the client to see her doctor. After a change in medication, the situation stabilized.*

Ronald *is 68 years old and has an IP who works 184 hours per month. His condition was stable but the case manager had to make about seven calls in 1998 to see about his food stamp application. The IP also needs to undergo surgery and the case manager is involved with trying to arrange for an agency to provide substitute care during the time the IP is recuperating.*

Mary *is 77 years old, deaf, and uses an arcane form of sign language that takes multiple interpreters. To conduct a reassessment, the case manager needs four interpreters. Her caregiver was able to teach her some self-care skills, and Mary's hours of assistance could be reduced from 74 to 52 per month.*

Grace *is a 62-year-old woman with Lou Gehrig's disease and has been on services for six years. Her condition improves and worsens, so her need for services goes up and down. Each time there is a change, the agency supervisor contacts Grace's case manager who goes to her home and does a reassessment.*

George *is 64 years old and requires 160 hours of assistance. He prefers to use IPs, but his caregiver turnover is very high. The case manager often has to mediate between George and former workers because George disputes the hours they worked. The case manager is notified by the police that George inappropriately touched a woman who came to interview for an IP position and that he tried to harass his last three caregivers. The case manager now has to deal with the demands of the previous employees and also resolve how George will get the care he needs to remain at home.*

Source: JLARC case files review.

The Nurse Oversight Program is currently undergoing changes that will allow AAAs more discretion in how nurses will be used, but that may also create a gap in oversight. Federal Medicaid requirements for annual nurse visits were recently removed. However, rather than eliminate nursing visits, AASA decided to retain the program with some operational changes. The new Nurse Consultation Program will allow nurses and case managers to target those cases which could use more intervention and to reduce or eliminate visits to clients who have no need for an oversight nurse. This change reflects a general belief within AASA that not all clients need or derive much benefit from a nurse visit. Another reason for the change is to prevent the duplication of services for clients who already receive medical services and nursing visits through *home health*.

New program creates gap in QA

However, neither AASA nor the AAAs knows how many clients will no longer receive visits, nor do they know how many of these clients are served by IPs or how many will continue to receive visits from a home health nurse. In the AAAs we queried, the nursing visit criteria they developed suggest that 40 to 60 percent of their total client caseload will no longer receive a nurse visit. For these clients, the additional oversight of the IP caregiver's performance that the nurse provided will also no longer occur. This program change thus raises a concern that a gap in quality assurance has been created.

Role of Adult Protective Services in Quality Assurance

Adult Protective Services (APS) within AASA is responsible for investigating claims of abuse, abandonment, exploitation, or neglect. APS has this role for all Medicaid funded and private-pay adults receiving in-home care services.

Data and communication problems exist

Our interviews with APS personnel and AAA personnel indicated that effective communication and coordination is not occurring throughout the system. Specifically, we found that APS could not tell us whether any of its 6,000 investigations in FY 1997 involved clients who are receiving in-home care services through Medicaid programs. Their data system also cannot identify how many investigations involved allegations against paid caregivers. In addition, our interviews revealed that AAA personnel are not

always made aware when there is, or has been, an APS investigation open on their clients.

IP Payment Issues

IPs report higher percentage of hours worked

How IPs are paid has been the subject of some controversy. Our study found that IPs report working a significantly higher percentage of their authorized hours than do agency workers. While there may be some legitimate reasons for the difference, the limited accountability and controls within the IP payment system are a concern.

Our analysis shows that in July 1998, agency workers delivered approximately 85 percent of the hours they were authorized to provide.[10] In comparison, IPs were paid by the state for an average of 97 percent of their authorized hours.[11] AAAs require their subcontracted home care agencies to report the percentage of contracted hours they were able to deliver to clients and the reasons why some hours were undeliverable. Some of those reasons include caregiver or client illness, vacations, or client's refusal of service. Because these are occurrences that should also occur with IP clients, the disparity between the two systems raises some concerns.

IP payment system lacks external controls

We reviewed how the state tracks how many hours IPs work, and found that attendance is not verified and IPs are not required to complete time sheets. Each month, a central database within DSHS automatically sends all IPs an invoice for the total number of hours they were authorized to work for the month. The IP must then fill in the number of hours actually worked and mail the invoice back to DSHS. The IP or the client can also inform the case manager ahead of time if all of the hours were not worked and payment can be adjusted accordingly. However, the only person required to sign off on the official invoice is the IP; neither the client nor the caseworker is involved.

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[10] Estimate taken from 15,988 client payment and assessment records for July 1998.

[11] For purposes of this analysis, we assumed that IP clients receiving monthly-rate services were receiving all of their authorized hours (since most of them actually receive more than this). We therefore excluded these IPs from this analysis to create a more equal comparison to agency providers who have no monthly-rate clients.

It is important to note that there are some reasons why IPs might be able to serve a higher percentage of their authorized hours than agency workers. For example, many IPs live with their clients and are likely to work even when sick. In addition, many IPs are family members and may be able to work around a client's schedule more easily. However, it is not known if there are legitimate explanations for the sizable difference in the percentages of hours served, and there are no controls in the system to catch illegitimate payment claims.

CONCLUSION

QA oversight should be more outcome-based

Washington's program for in-home personal care services does not have a formal quality assurance program, but consists of a mixture of formal and informal practices. There are many entities involved in providing oversight of program quality, and there are some important and useful practices currently in place. However, we found that many of the quality assurance practices used by AASA and the AAAs rely on administrative oversight requirements. Such oversight could be more effective if program performance is monitored in addition to, or in place of, existing administrative requirements. Our review also shows that while the case management responsibilities of AAAs have changed, AASA has not incorporated these changes into its oversight practices.

IP program has limited QA requirements

We also found that the system is designed in such a way that oversight, accountability, and control points are not equal when a client uses an IP versus an agency caregiver. Many of the system's quality assurance practices apply to clients served by home care agencies, but not to clients within the IP program. In addition, IP caregivers appear to serve a much higher percentage of their authorized hours than do agency caregivers. While there may be some legitimate reasons for the difference, the limited accountability and controls within the IP payment system are a concern.

Recommendations are made in this chapter to address the focus of quality assurance efforts and the need to provide greater oversight over IP reimbursement. The potential impact of less

oversight when an IP is providing service is considered further in Chapter Three.

RECOMMENDATIONS

Recommendation 1

The Aging and Adult Services Administration should incorporate performance monitoring elements of case management services into its monitoring of the Area Agencies on Aging.

Recommendation 2

The Aging and Adult Services Administration should strengthen the accountability controls over the Individual Provider payment system.

Recommendation 3

The Aging and Adult Services Administration should resolve the data tracking and communication problems with Adult Protective Services.

IN-HOME CARE: DIFFERENCES BETWEEN INDIVIDUAL PROVIDER- AND AGENCY-SERVED CLIENTS

Chapter Three

SUMMARY

Chapter Overview

As discussed in Chapter Two, different levels of quality assurance were found between the agency and Individual Provider (IP) programs. Through additional analysis presented in this chapter, we determined that IP-served clients score higher on vulnerability indicators than agency-served clients. While it is not apparent why these more “vulnerable” clients are more likely to use IPs, personal factors and some state policies appear to be influencing a client's “choice” of provider.

This chapter discusses: 1) how IP-served clients differ from agency-served clients according to selected “vulnerability indicators” 2) what factors may influence why clients use Ips, and 3) our recommendation to improve the quality assurance controls for the more vulnerable clients within the IP program.

COMPARISON OF IP-SERVED AND AGENCY-SERVED CLIENTS

To look at the differences between agency-served and IP-served clients, we analyzed client profiles based on their assessment information. Our client sample was drawn from July 1998 assessment and payment records and included about 16,000, or approximately 80 percent, of the state's in-home care clients.

Description of Assessment Process

Clients assessed for ADL needs

An assessment of the amount of care and number of hours clients need is done when clients first enter the system and annually thereafter unless their condition changes. The assessment includes an evaluation of the type and amount of daily assistance they need with their Activities of Daily Living (ADLs). These include such tasks as eating, bathing, dressing, and ambulating. In addition, further assessment is done of a client's need for additional "supervision" for either "cognitive assistance" or "unscheduled tasks." Cognitive assistance can include reminding clients when to take their medications or ensuring they do not wander out of the house. "Unscheduled tasks" (such as toileting) cannot be planned and require someone to be present in case the client needs assistance.

The amount of assistance needed with ADLs and client supervision determines the number of hours a client requires each month.[1] If fewer than 112 hours are needed, the client can choose between an IP and an agency provider. However, if more than 112 are needed, the client must choose an IP. Clients can also choose to use a combination of provider types; however, this is a relatively rare occurrence.[2]

Results of Comparison

Definition of "vulnerable"

A comparison of IP and agency clients shows that the populations are similar in some respects, but differ significantly in areas that might be considered indicators of "vulnerability." In this context we use "vulnerable" to mean that one is dependent on others to provide either large amounts, or critical types, of personal care or may lack the capability to supervise their own care.

The majority of IP clients are assessed to be more vulnerable than are agency clients. On average, IP clients scored higher on most of the vulnerability indicators we looked at when compared to agency

[1] Hours of care can range anywhere from a few hours a day for just a few days a week, up to the maximum of 24-hour care, seven-days-a-week (744 hours).

[2] Our analysis of July 1998 assessment and payment records shows that approximately 2.6 percent of clients have a combination of provider types.

clients, including the number of hours of care needed and clients abilities to self-administer their medications. The table below shows a summary of these results; please see Appendix 4 for the complete data.

Exhibit 5
Comparison of Vulnerability
IP and Agency Clients

Vulnerability Indicators	IP Clients	Agency Clients
Average Number of Assessed Monthly ADL Hours Needed	68.1	47.9
Average Number of Assessed Monthly Cognitive Support Hours Needed	72.1	17.8
Average Number of Assessed Monthly Unscheduled Task Hours Needed	113.6	31.6
Average Number of Authorized Monthly Service Hours	143.4	57.6
Percent Unable to Self-Administer Medications	80.0%	50.0%
Percent Having Substitute Decision-Maker	42.7%	57.3%
Percent Living Alone	26.3%	66.4%

Source: AASA July 1998 assessment and payment data.

IP clients assessed to be more vulnerable

Exhibit 5 compares IP-served to agency-served clients along potential vulnerability indicators. Higher percentages indicate higher vulnerability. Assessed hours are based on total client needs before program and financial eligibility for Medicaid services are established. Authorized service hours are those which AASA has agreed to provide each month, depending on the client's physical and financial needs.

However, our analysis also shows that there are other factors that might mitigate client vulnerability. For example, clients who have

IPs are far more likely to live with someone else.[3] Overall, just 26.3 percent of IP clients live alone, compared to 66.4 percent of agency clients. Unfortunately, determining how involved the other home resident(s) may be in overseeing, or providing additional care to, these clients is not available from the data analyzed.

Some clients unable to supervise caregiver

Our analysis also shows that 20.3 percent (1,729) of IP clients live alone *and* are considered "unable to supervise their caregiver." This is a determination made by the case manager during initial and follow-up client assessments and is based on a number of questions about the client's psychological, social, and cognitive abilities. As discussed earlier, under the IP program the client is considered the "employer" of the caregiver. Our concern is that a significant percentage of clients appears to hold primary responsibility for ensuring the caregiver provides quality care and for informing the case manager when there is a problem, yet these clients have been deemed unable to supervise their caregiver. A high percentage of agency clients (58 percent) are also considered unable to supervise; however, agency clients are *not* expected to be the "employers" of their caregivers and, on average, require much lower amounts of monthly care. As discussed in Chapter Two, additional quality assurance practices are in place for agency clients to help identify potential problems without relying solely on the client's ability to monitor the caregiver's performance.[4]

GROWTH IN USE OF INDIVIDUAL PROVIDERS

Percentage of IP clients increasing

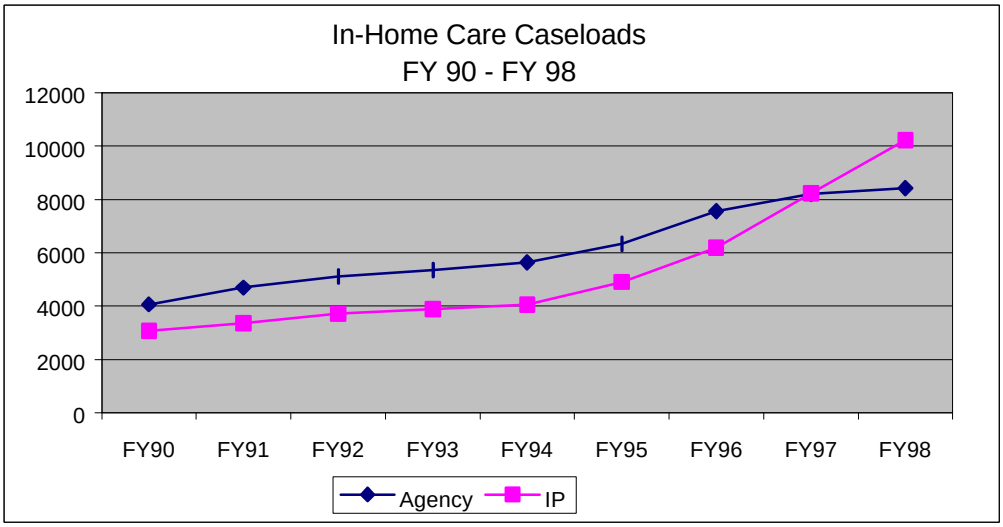
Over the last several years, overall in-home care caseloads have increased 61 percent, with the number of IP clients growing more rapidly than agency clients since FY 1996. As of July 1998, IP clients constituted 55 percent of the in-home care population funded

[3] Statistical regression analysis performed on the July 1998 data shows that Living with Others is the most significant variable in explaining what is different about IP clients. The two other significant variables were Non-English Speaking and Higher Number of Authorized Hours.

[4] Some examples include two caregiver supervisor visits per year, caregiver performance evaluations, and mandatory timesheets. These are required by DOH licensure regulations, and agencies are audited for compliance by the AAAs. Further discussion of this issue can be found in Chapter Two.

and agency clients constituted 45 percent.[5] In comparison, the split was 43 percent agency and 57 percent IP in 1990. Exhibit 6 below shows caseload changes between fiscal years 1990 and 1998.

Exhibit 6



Source: AASA caseload data. Excludes state-funded CHORE cases.

Potential explanations for IP growth

A number of client factors may be contributing to this trend of IP caseloads increasing and agency caseloads leveling off. While the full reasons cannot be identified, some of the factors may include:

- Recent liberalization of DSHS rules regarding the delivery of state-paid care by family members
- Expansion of IP program to include clients needing fewer hours of care
- Client lives with other people
- Increase in clients needing a caregiver who speaks the client's native tongue
- IPs being able to provide extended hours of care during nights and weekends
- Limited availability of agency services in rural areas
- New estate recovery laws requiring that the costs of in-home care be recovered from a deceased person's estate

[5] Includes COPES and MPC clients only. CHORE clients are excluded.

The family member rule previously only allowed non-spousal family members to be IPs if they met certain low-income and employment guidelines. However, in 1995 the WAC was changed to allow any non-spousal family member to provide services.[6] A recent AASA survey of all clients assessed during October 1998 revealed that 52 percent of IPs are family members. This pattern suggests that family members serving as IPs could be significantly affecting the recent trend. However, AASA has not been tracking data on the number of IPs who are family members, thus making it difficult to determine the influence this pattern has on the increasing IP caseload.

IP service eligibility expanded

Other factors can be more directly linked to the faster growth rate of IP clients. In 1995, AASA removed the requirement that all clients needing less than 85 hours must use an agency, giving them the choice of an IP. Historical data are not available to determine how many of these clients switched provider types as a result of the rule change. However, current data shows that approximately 30 percent of clients who have fewer than 112 hours (the 85-hour limit was recently raised to 112) now use IPs instead of agency caregivers.

CHORE caseloads reduced

In addition, in 1993 the Washington Legislature limited funding for the CHORE program–the state-funded, in-home care program providing assistance with household tasks. Consistent with this decision, AASA began reducing the number of slots available for new CHORE clients and shifted funding into federal matching fund programs such as COPES. CHORE services were traditionally provided by agencies, therefore reducing CHORE clients would clearly affect agency caseloads. A review of client data by funding source shows that CHORE cases made up 60 percent of total agency caseloads in 1990 and now make up only 10 percent. If CHORE cases are excluded, agency caseloads are still growing, although the overall growth rate has leveled off.

IMPLICATIONS OF THE 112-HOUR RULE

As just discussed, some individual client factors may influence what type of provider clients have, such as whether they live alone or

[6] DSHS WAC 388.15.196.

understands English. However, there is one AASA policy that appears to be very influential, and that is an upper limit on the number of hours of service that can be provided by an agency for one client. AASA requires that all clients who are authorized for more than 112 hours of monthly services must use an IP. Although some exceptions to this rule are allowed, there are very few of them; only 304 agency clients (4.1 percent) have more than 112 hours.

The 112-hour limit is not related to meeting particular amounts or types of client care needs. It is an artificial cut-off that is related to keeping overall in-home care costs below those of nursing facility costs. The agency hour limit was instituted in 1989 as an effort to accommodate the increasing numbers of clients and to contain the costs of in-home care. Because of the additional services, overhead requirements, and employee benefits provided by agencies, their hourly costs have always been higher than those of IPs. IPs are currently paid $6.18 per hour, and agencies are reimbursed at a higher rate of $11.33. While agency hours are capped at 112 per month, IP service hours are currently capped at 184 hours per month. The combination of limits on hours and hourly payment rates is intended to keep the cost of in-home care below 90 percent of the average cost of nursing facility care.

Limit not related to client need...

However, AASA is unable to document the rationale behind the specific decision to limit agency-provided hours to 85 (later raised to 112). When the limit was first established, only 90-100 clients were receiving enough service hours to be affected by the requirement. Today, over 7,000 clients in the IP program are authorized for more than 112 hours (the agency maximum).[7]

Because of budgetary constraints, federal COPES funding requirements, and the need for affordable community-based long-term care options, we understand that it is critical to keep the cost of in-home care below that of nursing facilities. However, the use of a somewhat arbitrary hourly limitation that directs the most needy clients into the part of the system with the least controls raises concerns. The IP program might be a cost-effective alternative to

...and directs most needy clients into IP program

[7] Estimate based on data for 16,000 clients and extrapolated to the July 1998 total of 19,780 in-home care client population; 36.3 percent of clients in this data-set have authorized hours of over 112; 36.3 percent of total July client population is 7,180.

agency care, but there needs to be adequate oversight and quality assurance.

OPTIONS FOR PROVIDING QUALITY ASSURANCE OF INDIVIDUAL PROVIDERS

Addressing the need for greater quality assurance, oversight, and accountability over IP caregivers is not simple, and there are many ways such an initiative could be approached. There is no consensus about what works best but there are many models to consider.

Options are available

For example, there are states that use only agencies to provide services. Another model is used in Oregon where only IPs are used and "supportive" services are offered to clients to assist in their job as employer.

In the private-pay system, caseloads are commonly much lower. Therefore, a private-pay client can expect much more personal and regular contact. A team of people that includes health care specialists may also oversee services.

Other social service programs, such as Washington's Birth to Three Program for children with disabilities, use agency workers as case managers and save DSHS case managers for those clients who utilize services "ala carte." Structured caseload weighting systems can also be designed to allocate case manager caseloads according to the level of vulnerability of their clients. Another potential approach is to develop formal criteria for identifying potentially vulnerable clients (such as those who live alone and have cognitive impairments) and establish additional QA oversight measures for them (such as additional case manager contacts or visits). This is similar to the approach AASA is currently using for its new Nurse Consultation Program for medically unstable clients.

CONCLUSION

In summary, IP-served clients are a more vulnerable population than agency clients, especially given the lack of oversight in the IP program. Also, the IP caseload is growing, most likely due to both client choice and department and state policies.

We do not know what the outcomes of these policies are in terms of ultimate impacts on client health and well being. However, AASA has a policy that requires a growing number of elderly and disabled clients to use a care environment with fewer controls. Solving issues related to improving quality assurance should be part of this policy responsibility.

Growing IP caseload requires attention to QA

RECOMMENDATION

Recommendation 4

The Aging and Adult Services Administration should improve its quality assurance controls for the more vulnerable clients within the Individual Provider program.

SCOPE AND OBJECTIVES

Appendix 1

SCOPE

This review focuses on quality assurance for in-home care services (Medicaid Personal Care, CHORE, and COPES programs) provided to elderly and disabled persons by agency and individual providers administered by the Department of Social and Health Services (DSHS) (Aging and Adult Services) and Area Agencies on Aging.

OBJECTIVES

- Evaluate the extent of current quality assurance practices and, to the degree possible, the effectiveness of those practices.
- Identify relevant national standards or quality control measures used by selected states.
- Determine, if possible, the reasons for faster growth rates in the use of individual providers than in the use of agency providers of in-home care.

AGENCY RESPONSES

Appendix 2

- **Department of Social and Health Services**
- **Office of Financial Management**

To link to this appendix, click here.

ILLUSTRATIVE INDICATORS OF HOME CARE QUALITY

Appendix 3

Illustrative Indicators Of Home Care Quality

Outcomes	Physical functioning (ADL & IADL measures) Physiological functioning Symptom control/pain Social functioning (activities, contacts) Client knowledge of disease and care Family knowledge of disease and care Compliance with medication Compliance with other care regimens Sense of safety/security Satisfaction with care Satisfaction with home environment Family satisfaction Family well-being/stress levels Mortality Morbidity (sickness, complications) Hospitalization Admission to Nursing Home Admission to Congregate Living (other than nursing home) Death Adverse health outcomes-bedsores, infections Client choice Client complaint resolution Unmet need
Process	Appropriateness of home care Appropriate disease-specific treatment Timely post-hospital care Appropriate intensity of home care Correct disease-specific/problem specific care (e.g. skin care, diabetic care, chemotherapy, ostomy care) Identification of new conditions/exacerbations Correctness of assessment and care plan Client choice
Structure	Qualifications of staff - basic and extra training Supervision of staff Recording practices Administrative practices Coordination
Enabling	Caregivers show up as expected/stay as expected Honesty--no theft, exploitation Kindness, courtesy, patience No physical or verbal abuse Compatibility between client and caregiver Caregiver respects client's wishes--does it client's way Caregiver respects family expertise Clients know what to expect--i.e. expected schedule & tasks Timing of care accords with client preference

Source: Rosalie Kane, D.S.W., *Quality of Home Care: Concept and Measurement*, February 1991.

COMPARISON OF AGENCY AND IP CLIENTS BY "VULNERABILITY" FACTORS

Appendix 4

Appendix 4
Comparison of Agency and IP Clients by "Vulnerability" Factors

Vulnerability Factors	IP Clients	Agency Clients	More than 112 HRS		Less than 112 HRS	
Number of Clients	**8505**	**7483**	**IP (5501)**	**Agency (304)**	**IP (3004)**	**Agency (7179)**
Avg. Age	66	71	67	73	66	71
Avg. ADL Score	98.7	67.8	109.9	112.5	78.0	66.0
Avg. ADL Assessed Hours	68.1	47.9	75.5	77.2	54.6	46.6
Avg. Cognitive Hours	72.1	17.8	99.8	86.7	21.4	14.9
Avg. Unscheduled Task Hours	113.6	31.6	154.8	154.1	38.3	26.4
Avg. Number of Supervisory Hours	185.7	49.4	254.5	240.8	59.7	41.3
Avg. Total Assessed Hours	253.8	97.2	330.1	318.0	114.2	87.9
Avg. Total Authorized	143.4	57.6	187.7	178.2	62.3	52.5
Avg. Number of Medications	6.5	7.0	6.6	7.5	6.3	7.0
Percentage Able to Self-Administer Meds						
Yes	19.0%	50.0%	12.9%	17.8%	30.3%	51.4%
Needs Reminder	25.5%	22.9%	21.1%	18.1%	33.4%	23.1%
Physical prep needed, may need reminder	15.0%	8.9%	16.5%	18.1%	12.5%	8.5%
Physical prep needed, dosage determined, may need reminder	19.7%	11.3%	22.7%	22.7%	14.3%	10.8%
Must be administered to person	20.3%	6.4%	26.5%	23.0%	9.0%	5.7%
Unknown	0.4%	0.5%	0.4%	0.3%	0.5%	0.5%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percentage by Living Arrangement						
Alone	26.3%	66.4%	21.4%	45.1%	35.2%	67.3%
Not Alone	73.7%	33.6%	78.6%	54.9%	64.8%	32.7%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percentage by Substitute Decision Maker						
No	42.7%	57.3%	64.0%	62.5%	45.1%	41.9%
Yes	57.3%	47.7%	36.0%	37.5%	54.9%	58.1%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percentage Able to Supervise Care Provider						
No	66.0%	82.6%	59.0%	66.8%	78.7%	83.3%
Yes	13.1%	4.7%	17.2%	13.8%	5.7%	4.3%
Varies	19.8%	11.6%	23.1%	18.4%	14.0%	11.4%
Unknown	1.0%	1.1%	0.7%	1.0%	1.6%	1.1%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: AASA July 1998 Comprehensive Assessment and SSPS Payment records (15,988 in-home client cases).